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ABSTRACT

An approach to occupational therapy (OT) in a rural school is described which utilizes a combination of direct service, monitoring, and consultation. A collaborative style of OT consulting is used, which calls for the therapist to join the child study team when motor-related problems are identified. The approach provides continuous and uninterrupted services to meet individual student needs, by involving the family, special educators, and classroom teachers. It attempts to make the OT's knowledge and expertise available to help the regular classroom teachers with the problems of students with motor disabilities, as well as everyday problems which do not make students eligible for special education services, such as poor coordination, poor fine motor skills, and poor handwriting. On-going communication is the most important component of collaborative consulting; this communication takes place through the therapist's participation on the child study team, completion of assessments, establishment of goals and objectives, provision of direct treatment, supervision of indirect therapeutic services, and consultation. Examples of the method's successes are described. Also discussed are the historical framework of occupational therapy, practical aspects of identifying appropriate students, training staff, carrying out daily programs, and record-keeping. (JDD)

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Occupational Therapy Consulting Through the Resource Room: Collaboration in Rural Education

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Paper presented at the Annual Convention
of the Council for Exceptional Children
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Abstract

Discussion of the the theoretical framework of occupational therapy and how it can be integrated successfully into the public school setting through coordination by a multi-disciplinary team with emphasis on the role of resource room. Management of indirect occupational therapy programs through the resource room teacher is described. Four types of consultant styles are reviewed as well as some practical aspects of identifying appropriate students, training staff, carrying out daily programs and record keeping. Specific diagnostic catagories of students served are described and patterns of occupational therapy/school/home interaction are outlined. Meeting the needs of high-risk students are addressed.

Occupational Therapy Consulting Through the Resource Room: Collaboration in Rural Education

Organized consulting between occupational therapists and resource room teachers benefits all school children. Such a program of consulting has evolved in several rural schools in western Wyoming. The specifics presented here for sharing this organizational system have grown from a four-year association at a small, geographically isolated elementary school between an occupational therapist (OT) and a resource room teacher.

Currently there is a nationwide shortage of OT's and our school was privileged to have the services of an OT twice a month. However, since several students needed motor activities twice or 3 times a week, a collaborative approach was implemented and a

successful OT consulting program developed.

Problem solving and practical information was exchanged between the OT and the resource room teacher, the regular classroom teachers and aides, as well as the art, music and PE teachers, related service specialists, and the family. Questions and answers, suggestions, ideas, progress monitoring, etc. reach the OT directly or are channeled through the resource room teacher. Collaborative consulting is based on working together and learning to communicate effectively and efficiently.

Since the OT may visit the school weekly or bimonthly, her time is usually spent on the students with more severe problems. To increase the continuity of programming for these children in the school environment this approach is action-oriented toward the classroom. This results in increased knowledge and expertise for the regular classroom teacher about motor development and related classroom problems.

Historical Framework

Occupational therapy is a para-medical profession

which has its roots in the rehabilitation centers of the post World War I era. The profession's early evolution was within the medical setting, treating the disabled and handicapped under a medical doctor's supervision. Those first patients were amputees, upper extremity injuries with loss of sensation and/or mobility, strokes, heart attacks, head injuries and emotional disabilities.

Occupational therapy concentrated on improving muscle strength, range of motion, self-help skills, and a return to a "normal" life through the use of purposeful functional activity. This was the beginning of the medical model. Throughout the past 60 years this profession has continued to evolve and now provides a broad range of services in nursing homes, developmental centers, mental health settings, home health care situations, rehabilitation and educational institutions. Throughout these times of change, the common thread has been the use of purposeful activity to gain or restore function.

In the educational setting, occupational therapy has been identified as a related service and is

provided for by Public Law 94-142. Within the public school setting, occupational therapy treatment must have a direct impact on the students' ability to benefit from their educational programs. This would be more typical of an educational model as compared to a medical approach. Occupational therapists in public schools may be employed as: full-time or part-time school district staff, sub-contracted from other agencies, as independent contractors hired to work with specific students, or as consultants.

Nationwide we are seeing changes in the health care delivery system shaped by fiscal shortages and an increased need for occupational therapy personnel. The Ad Hoc Commission on OT Manpower identified and described the personnel shortages of therapists and assistants (American Occupational Therapy Association, 1985). Currently the situation is worse and is expected to be further impacted by (a) full implementation of 1987 Medicare Amendment, (b) the Early Intervention Amendment (Public Law 99-457) which will exacerbate shortages in schools, (c) rapid growth of the elderly population over the next 10 years,

(d) nursing home population expected to double after the year 2000, (e) rising survival rates from accidents, trauma, and birth defects, and (f) the increased health care focus on chronic disability and disease.

Meanwhile, educational institutions are often placed in the awkward position of justifying the need for services, becoming responsible for providing occupational therapy, and finding the specialists to implement these programs. Occupational therapists have been trained to deliver direct services to clients by providing treatment for individual problems in a one-to-one small group format. This type of delivery (the medical model) is often very effective for children but is also costly and not always the most appropriate. Therefore, it is unrealistic to expect its exclusive use in the public schools. A collaborative consultative approach combining direct and indirect service delivery can be a viable alternative to traditional direct service.

Models of Service Provision

Specific models for school-based occupational therapy have been defined (American Occupational Therapy Association AOTA 1987). The most appropriate service model is based on careful assessment of the student's needs by the interdisciplinary team within the context of the educational placement. The type and amount of service provision may not be determined by parental wishes or district resource limitations such as space, personnel shortages, or time constraints. It should be determined by the student's individual needs. Understanding the following three models will help in choosing the most appropriate service option.

1. Direct service is the most familiar model. The occupational therapist uses specific techniques with one student or a small group of students, usually one to three times a week. The therapist is responsible for all aspects of a student's program. "The critical feature in choosing direct service is

the identification of an educational need that can be met only by direct interaction between the student and the therapist" (Dunn, 1988). One research study investigated direct services to children with severe disabilities. Those who received direct therapy made greater gains than those who did not (Ottenbacher, Short, and Watson, 1981). Another study looked at the intensity of direct service, comparing once a week and three times a week (Jenkins, et al, 1982). The authors found no difference in the results they produced and concluded that multiple sessions may not always be necessary.

2. The monitoring model of service provision requires diagnostic skills to identify student needs, program planning skills to design appropriate interventions, and teaching and supervisory skills to assist others to carry out the procedures. Regular contact (a minimum of twice a month) is needed to determine whether the program and procedure adjustments are necessary (AOTA, 1987). The occupational therapist is responsible for outcomes,

but another person is entrusted with the regular implementation of the program plan. "The most critical feature of monitoring is the identification of an educational need that will best be served by routine and consistent procedures needing on-going guidance and practice" (Dunn, 1988). Three questions are asked to determine whether monitoring is a safe choice for a student: (a) Is the student's health and safety protected during programming carried out by a person other than the OT?, (b) Can the person being trained demonstrate the activities without assistance?, and (c) Can the person being trained independently describe restrictions and signals of failure, know when to stop, and when to contact the supervising therapist? One should be able to answer an emphatic yes to all three questions. Research indicates that students perform at higher levels when therapy techniques are integrated into educational strategies (Campbell, McInerney, and Cooper, 1984).

3. Consultation in education helps adapt the environment and alter teaching strategies through the

use of specialized expertise. "The most critical factor in choosing consultation is the identification of an educational need that is most effectively met through a supportive environment" (Dunn, 1988). This can be an effective means to offer the student the opportunity to generalize their skills to different environments and to efficiently use the OT's knowledge. Designing proper seating or positioning, preparing an adaptive device or writing tool, or assisting with Individual Education Plan (IEP) development can all be considered examples of consultation. OT consulting in special education can facilitate a more supportive environment and better outcomes for the student.

Each model has benefits and limitations. Direct therapy is costly and time-consuming but can address complex problems and be quickly adapted to the student's changing needs. Monitoring is more time-efficient since others carry out the programs, but the student's health and safety must always be considered. Consultation is an effective mechanism

for providing on-going environmental support but requires special skills to be administered properly. Our approach has utilized a combination of all these models into one effective style based on the provision of continuous and uninterrupted services to meet the needs of the individual student.

Theoretical Framework

Consultation is not a new role and has been documented in the literature during the past thirty years. Most of this information comes from the fields of medicine, mental health, school psychology, and organizational development (Dunn, 1985: Idol & West, 1987; West & Idol, 1987). Consultation refers to services provided by a professional to some other person who is in direct contact with a child or client. It involves a triadic relationship in which the focus is on the skills or behavior of the child. Adult communication is critical to successful outcomes.

Winnie Dunn, Ph.D., OTR, FAOTA sites four major consultation styles that might be applied to the

education setting (Dunn, 1985):

1. Expert Model: The consultant develops recommendations and carries them out. Initially, the teacher might describe concerns. The expert consultant will use that information to identify the problem to be addressed and to plan or implement recommendations. There is no follow-up in the expert model of consultation. Some behavioral programs are established in this manner.

2. Medical Model: The teacher describes concerns to help identify the problems. The medical consultant formulates recommendations and delivers them to the teacher for implementation. Follow-up is available but is usually provided only if the teacher requests it. Most of us experience this model when we visit our family doctor.

3. Mental Health Model: The goal of the mental health consultant is to improve the teacher's ability to manage a similar problem in the future. The consultant tries to help the teacher identify the problem through the process of clarification. The

teacher describes his or her perception of the situation and the consultant reacts to this information; this continues until there is agreement about the exact nature of the problem, and an intervention plan evolves. The teacher implements the plan and can request further intervention.

4. Collaborative Model: The consultant works with the teacher to identify the problem and to plan and carry out recommendations. Both persons work together throughout the process; each may be responsible for part of the plan. There is continuous follow-up and alterations are possible at each step along the way. This sometimes seems impractical because it requires not only commitment from the teacher and the consultant but also approval of the system. However, the benefits can be great due to the personal commitment that each participant must make.

The consultant's function within any model is to provide needed knowledge to the educational setting (classroom, playground, lunchroom, etc.) and to allow

that knowledge to create changes. The consultant offers advise, skills and knowledge. The educational setting determines when and how to use it. The individual consultant is an authority on his/her own topic but not necessarily in the classroom, identifying with the goals of the setting without actually being a part of it.

The goal of consultation is to provide resources so that the consultee can fruitfully solve problems, create new programs, and better serve their students. The emphasis must be kept within the context of Public Law 94-142, enhancing the student's ability to benefit from educational programs. The collaborative approach has potential to provide expert practical help to children in the resource room, in regular classrooms, and throughout various school settings.

In a study of preference for consultation styles (Babcock and Pryzwansky, 1983; West, 1984) classroom teachers, special educators, and principals were asked to rate consultation styles. In crisis situations educators prefer expert consultation. In other

situations the collaborative style was preferred. Educators want to be involved in remedial programs. They also found that teachers exposed to the collaborative approach implement more recommendations and have a more positive attitude toward services received.

The Collaborative Style of OT Consultation

The collaborative style of OT consultation serves certain types of children and involves particular patterns of OT, school staff, and home interactions.

The approach is multi-disciplinary following the guidelines of Public Law 94-142. The OT joins the Child Study Team when motor related problems are identified. The OT consults with the family, special educators, and classroom teachers. Such on-going consultation helps to maintain continuity throughout the school day, to update student progress, and to help solve problems that arise. OT service delivery to students with IEP's is usually a combination of direct treatment and indirect motor reinforcement programs, as well as consulting.

Types of children served by the OT Consultant in the educational setting are the following:

1. Orthopedically handicapped or other health impaired: (a) may have physician's referral; (b) have IEP; (c) may receive direct or indirect OT services in groups or individually; (d) may qualify for Resource Room help (monitoring, remedial assistance).

2. Special Education students (Educable Mentally Retarded [EMR], Learning Disabled [LD], Speech and Language Impaired, etc.): (a) eligibility determined by district / state regulations; (b) have IEP; (c) may receive direct OT services in groups or individually, or resource room help (monitoring, remedial assistance, indirect OT).

3. Students referred for an initial evaluation when motor concerns are identified by a classroom teacher or the screening committee.

One particular student who received OT services was orthopedically handicapped with mild cerebral palsy (CP). Six years ago her school had an OT come weekly. For the next four years the OT was only able

to come bi-monthly and there was a need for more frequent OT activities. Services twice a month were not enough to effect a change or to maintain skills. By the end of that first year the student was provided with motor reinforcement activities twice a week.

This student's mild CP condition resulted in a left-sided weakness. Her IEP included goals for balance and symmetry, left-sided stability, and bilateral coordination. The following 3rd-grade goals show the basic skills to maintain and improve: (a) She will demonstrate improved ability to use the two sides of her body together for gross and fine motor activities, (b) she will demonstrate improved balance for static as well as dynamic activities, and (c) she will demonstrate improved visual-perceptual motor skills.

The pre-levels of performance data justified these goals. She needed to learn compensatory skills to coordinate both sides of her body, to maintain balance in physical education activities, to get on and off the bus safely, and to be able to sit down and get up

from her desk without stumbling.

By the end of that school year, this student's IEP was expanded from 60 minutes.twice a month to 60 minutes each week for OT. These motor reinforcement activity sessions were 30 minutes long twice a week. They were carried out by the resource room teacher as the designated staff person. The OT trained the resource room teacher and monitored the motor reinforcement activities.

This student is a success story of collaborative consulting. Her OT goals focused more on life skills and on regular classroom skills. Her weakness is not very noticeable. She is developing responsibility for her own exercise program. Her principle 6th-grade OT goal was a monitoring goal for maintenance and improvement of her left-sided strength and flexibility. Part of this goal prescribed 10 minutes of daily exercise at home or school. The remainder of her goals combined OT and resource room objectives.

Another special education student qualified for OT

services because he had motor and visual perception deficits. At that time he was a 3rd-grader, classified as EMR and receiving services from the resource room, OT, and speech and language therapy. This child is high functioning and definitely educable. He is difficult to understand in conversation. His behavior is non-assertive and sometimes passive aggressive. His right leg has been weaker since birth, but most of his gross motor skills are adequate to fair. He has low muscle tone with decreased strength and endurance. He often watches games from the sidelines at recess. His OT goal was to maintain and increase his balance and gross and fine motor skills. He is in regular class for his reading and math program. He has good visual sequential memory, a good sight reading vocabulary, and is a fair speller.

This child's major classroom difficulties are with reading comprehension, working independently, cutting and handwriting. He is left handed, often writing either too large and messily or too small. At

this time he was learning cursive and had difficulty with the rhythm and flow.

Figure 1 is an example of the OT evaluation for this child's IEP. Notice his chronological age of 9.9 years and the difference between his gross motor skill subtests: Age Equivalents Running Speed/Agility 4.11, Balance 5.5, as compared to Strength of 10.2 years. The Gardner Test of Visual-Perceptual Skills (non-motor) shows his previously noted Visual Sequential Memory Skills with a Percentile ranking of 63 compared to the other subtest scores, all considerably lower. Knowing this skill strength area explains certain classroom successes and implications for individual programming in the classroom.

The third type of student served benefits regular education directly. The OT would conduct an evaluation for the child if he is referred and motor concerns are identified by the classroom teacher or screening committee. The fine and gross motor skills of handwriting and spelling are sometimes major obstacles for children. Referrals for this at-risk,

Name: [redacted]
Date: 12-3-87
Birthdate: 3-31-78
Age: 9.9 years Reporter: R.R. Donaldson, OTR

[redacted] is a third grade boy who has received a combination of indirect and direct occupational therapy at the Alta School for approximately 30 minutes weekly. Treatment goals have emphasized the development of bilateral integration, balance skills, and fine motor speed and precision as well as monitoring visual-perceptual skills through the resource room/classroom. Following is a summary of recent testing:

Bruininks-Oseretsky Test of Motor Proficiency:

Gross Motor Subtests/	Age Equivalent/
1. Running Speed/Agility	4.11
2. Balance	5.5
3. Bilateral Coordination	7.11
4. Strength	10.2
5. Upper-Limb Coordination	9.2
Fine Motor Subtests/	
6. Response Speed	8.11
7. Visual-Motor Control	9.2
8. Upper-Limb Speed/Dexterity	6.11

Composite Scores.....Percentile Rank
Gross Motor.....2nd.
Fine Motor.....10th
Total Battery.....3rd

Developmental Test of Visual-Motor Integration:

Raw Score.....	9
Age Equivalent....	5.3
Standard Score....	3
Percentile.....	<1st

Test of Visual-Perceptual Skills: (non-motor)

Subtest:	Perceptual Age:	Scaled Score:	Percentile:
1. Vis. Discrim.	8.2	9	37
2. Vis. Memory	7.8	8	25
3. Vis.-Spatial Rel.	8.0	9	37
4. Vis. Form Constancy	5.11	4	2
5. Vis. Seq.-Memory	10	11	63
6. Vis. Figure-Ground	8.10	9	37
7. Vis. Closure	8.10	9	37

Figure 1. OT evaluation, EMR third grader

failure-prone child are often appropriate.

However, all children having problems can't be referred or even evaluated. Many rural schools are lucky if they have access to OT, and restrictions about which children they are able to see is a practical reality. We did not experience a flood of referrals. Most schools have some perplexing students that are definitely at-risk-for-failure. Some problems need more input from an individual evaluation. What one does by prescription from an individual assessment, may often apply to problems which other students exhibit. Classroom teachers can generalize that information to other students.

The more the classroom teacher knows about motor and visual perception problems, the better for all students. Some of these children referred may not become eligible for special education services. Yet, they may have poor coordination, poor fine motor skills, poor handwriting, be distractible, over-active, clumsy, or become a class discipline problem. Many times the same intervention techniques

and educational approaches apply to the children with less severe problems. This collaborative style of consultation attempts to make the OT's knowledge and expertise available to help the regular classroom teacher with some of these everyday problems.

On-going communication is the most important component of collaborative consulting. There are particular patterns of interactions defined by roles, IEP paperwork, consulting, direct and/or indirect OT services:

1. The OT is a member of the Child Study Team for any students who have been evaluated or have OT goals and objectives in their IEP.

2. The OT completes requested assessments for referred students. This occurs as part of the referral process. When the classroom teacher or screening committee identifies motor problems such as balance, gross motor skills like running, hopping, skipping, and throwing; fine motor skills of writing, cutting and manipulation; or visual perception difficulties.

3. The OT formulates long-term goals and short-term objectives as part of the IEP process, selecting appropriate treatment techniques and revising the goals and objectives as needed.

4. The OT consults with classroom teachers regarding their concerns, goals and objectives. They also do follow-up and monitor progress for students with IEP's. They provide classroom and home recommendations for ineligible students. They also meet with the parents when appropriate and communicate with other teachers working with the student such as art, music, and PE.

Scheduling is the big obstacle here. Yet, if the OT can remain flexible and utilize the time periods before or after school, recess, lunch or prep times; this kind of collaboration can be accomplished. Everyone in a school is busy. Whoever initiates staff interactions must remain sensitive to timing and the personal needs of other staff members.

Many times the initiative must be taken by the OT to increase basic awareness of other teachers about

motor concerns. This process is informational and on-going -- a two-way inservice. The knowledge of educational goals and techniques is not part of an OT's training. This give-and-take of information and ideas lays the groundwork for equal status. It's the two-heads-are-better-than-one approach, when there is a student problem. Knowledgeable advice, help and ideas are available to teachers. In addition, teachers spend more time with students and have meaningful information that can help the OT establish the most appropriate program.

5. The OT provides direct treatment as recommended in a student's IEP. This would be carried out in either an individual or a small group setting.

6. The OT sets up and supervises indirect OT services as recommended in the IEP, either individually or in small groups. The OT would provide training to school staff in carrying out the motor reinforcement programs. The OT would assist the administrator in selecting the appropriate person(s) to carry out these programs. This person could be the

resource room teacher, special education aide, PE teacher, or a regular classroom aide. The OT could also assist the administrator in the formulation of guidelines for the school staff carrying out motor reinforcement programs, and provide on-going training to the school staff carrying out the programs. This includes monitoring staff performance to help facilitate each student's appropriate responses, and to know what an appropriate response is or is not.

The OT may adjust the treatment activities as needed to be sure they aren't too easy or too hard, based on feedback from the staff and the treatment record. Figure 2 is an example of the Teton County School District #1 Special Education Technical Support Manual (Technical Support Manual, 1987). "Direct reinforcement motor support services" are described with specific procedures (Section C).

OT Roles in an Educational Setting

A major component of the OT's role in the school is to consult with the classroom teachers. The OT monitors special education students with OT programs.

TETON COUNTY SCHOOL DISTRICT NO. 1

SPECIAL EDUCATION DEPARTMENT

Jackson, Wyoming

TECHNICAL SUPPORT MANUAL

10. RELATED SERVICES: OCCUPATIONAL THERAPY

(A) Occupational Therapy services for special education children in the Teton County School District will include:

a. improving developing or restoring functions impaired or lost through illness;

b. improving ability to perform tasks for independent functioning when functions are impaired or lost; and,

c. preventing, through early intervention, initial or further impairment or loss of function.

(B) As we plan to meet the needs of the children identified as qualifying for Occupational Therapy services, three levels of delivery will be considered:

a. direct Occupational Therapy services for children identified as meeting the above noted critera (a., b., and c.);

b. consultation and follow-up services for children with less significant motor difficulties; and,

c. recommendations to teachers for children with sensory or gross motor needs which do not have a significant bearing on the child's ability to learn. Recommendations can be implemented by either a parent, regular education teacher or Resource Room Specialist.

(C) To appropriately provide services to students with gross and sensory motor special needs, support personnel, in addition to Occupational Therapist, will address the unique individual concerns of students with motor needs. To accomplish this, support personnel, from time to time, will be asked to provide direct reinforcement motor support services. These services and personnel responsible for providing the services will be documented in the child's Individual Educational Plan.

a. Support personnel working with students with sensory and gross motor needs will discuss these unique needs with our Occupational Therapist prior to providing services to those students.

b. Training and inservice activities will be provided to the support personnel prior to implementing specific I.E.P. objectives and goals. This inservice may take the form of, but is not limited to, direct observation of student/therapist working together, educational materials in the area of gross and sensory motor needs, attendance at workshops and conferences that specialize in gross and sensory motor areas, etc.

c. Students using specialized Occupational Therapy equipment will be supervised at all times by either the Occupational Therapist or support service personnel who have been assigned to work with the student.

d. Range of motion activities that are active in nature (child self-directed) are activities which can be supervised by both the Occupational Therapist and support personnel. Passive (teacher, therapist manipulates) activities for students with unique motor needs will only be done by a trained Occupational Therapist. Resistance activities will be noted as either active or passive and these activities will be identified in the child's I.E.P.

e. Massage, deep pressure and release techniques and the use of vibrators will be done only under the direct observation and supervision of a trained Occupational Therapist.

(D) Occupational Therapy services will be provided by: Occupational Therapist.

Figure 2. Motor reinforcement program guidelines

The teachers of mainstreamed students need help with the everyday problems of the regular classroom. If adaptations are used for a physically handicapped child, such as foam on the seat, then the OT must follow up to be sure it is working.

Finding time to meet with the regular classroom teachers, and art, PE or music staff can be a scheduling nightmare. There is input at IEP meetings, but much of the communication and interaction takes place during a teacher's few free moments throughout the day.

Collaborating means that the staff and the OT in particular, need to be available to those working with students having problems. Again, the aim is to provide consistency and continuity. Sometimes these consultations are impromptu and spur-of-the-moment.

The OT also provides classroom and home recommendations for the ineligible students who have been referred for special education assessment. Their evaluation would have an OT assessment if motor

deficits were identified.

For example, a kindergartener was evaluated because his teacher expressed concern about his difficulties learning to use a pencil and scissors. The child compensated with an unusual hand grasp that appeared abnormal. Did this child have a neuromuscular problem? The referral was made and an OT evaluation was included, but he didn't qualify for services. His problems were not severe enough. He was developing slowly as an immature five year old.

After this evaluation, the expanded role for the OT consultant provided extra help for this student. His lack of early school success made him definitely at-risk for school failure. The OT wrote a list of skills to be developed. This list was given and explained to his regular teacher and to his parents.

Figure 3 was written in activity form and includes behaviors that all young children develop. Most of these skills had come more easily to his peers. The OT met with his classroom teacher on several occasions to discuss classroom strategies and methods for

Name: [redacted]
Date: 1-8-88
Birthdate: 8-5-82
Age: 5.5 years

School: Alta
Grade: kindergarten

Occupational Therapy Consultation:

Gross Motor Skills to be Developed:

1. Stands on 1 foot 10 consecutive seconds
2. Jumps forward 10 times without falling
3. Walks on balance beam- forward, backward, sideways
4. Jumps backwards six times
5. Bounces and catches large ball using two hands together
6. Hops on either foot 5 times
7. Skips alternating feet
8. Alternates feet on stairs- up and down
9. Swings initiating and sustaining movement
10. Pedals tricycle easily changing, controlling direction

Fine Motor

1. Makes clay shapes using two hands together to shape balls
2. Cuts on a curved line
3. Screws threaded objects (nut and bolt)
4. Cuts out two inch circle
5. Imitates various direction lines
6. Spread fingers touching thumb to each finger, both hands
7. Hits nail with hammer
8. Cuts picture from magazine, no more than 1/4" deviation
9. Uses pencil sharpener
10. Traces outline of pictures in magazine
11. Tears simple shapes from paper
12. Catches soft ball, bean bag, or ties shirt with one hand

Figure 3. Developmentally immature kindergartener

modifying expectations. The teachers and parents of these children who do not qualify for special education services may need guidance in learning how to help in other ways. They benefit from the team suggestions about a child's strengths and weaknesses.

The OT communicates with the other teachers, (usually art, PE and music) who work with OT-served students. Such meetings are hard to fit in and are realistically the least likely to occur if scheduling probems arise. Good communication here is the extra; collaboration at its best. PE teachers especially are concerned with gross motor problems like hopping, skipping, running, and upper extremity control for throwing and catching. Art teachers may be concerned about fine motor problems with manipulative skills and eye-hand coordination.

Many times the resource room teacher may be central in coordinating questions and input that teachers have for the OT. This communication flow is dependent on staff schedules. One recess was filled with a 10-minute inservice session about

handwriting skills geared toward 3rd graders with OT goals. Posturing and warm-up activities were described. Figure 4 is an example of handwriting suggestions for these students. This was an effort to coordinate techniques and performance standards between the regular classroom teacher, classroom aides, and the resource room. Such consulting could also include follow-up for using specialized equipment or specific feeding techniques if needed.

Another role of the OT consultant is to set up and supervise indirect OT services, as recommended in the IEP, when motor reinforcement activities are indicated. These programs would be carried out by the designated staff person and determined on an individual need basis. Some activities could be incorporated into an academic resource room lesson. Specific activities assigned by the OT would be carried out. If staff members carrying out the motor reinforcement activity did not feel comfortable or did not fully understand, they would stop that activity until more discussion and training occurred.

Occupational Therapy Services
Teton County School District #1
Jackson , Wyoming 83001

Handwriting Suggestions:

[redacted] and [redacted]
Alta School
4-8-88

1. Provide tactile-proprioceptive warm-up prior to practice:
   A.) polishing and rubbing palmar and dorsal surface of both hands firmly

   B.) deep pressure pinch to palmar surface of hands and fingers using tip of thumb

2. Monitor appropriate sitting posture: feet flat, knees and hips bent at 90 degrees, chair forward with back supported, sitting slightly forward resting both forearms on table top and using non-writing hand to stabilize paper, head up and symmetrically oriented, not down or tilted. Use non-verbal, physical cues to remind student as needed.

3. Monitor appropriate paper placement and position:
   A.) [redacted]...left corner tilted up, paper in midline

   B.) [redacted]..right corner tilted up, paper in midline

4. Monitor appropriate grasp:

   A.) [redacted]'s reminders-
   1- Use stetro pencil grip with index finger on the star (arrow pointing up)
   2- keep fingers on painted part of pencil rather than wood if not using stetro

   B.) [redacted]'s reminders-
   1- Use setro pencil grip with thumb on star (arrow pointing up)

Rhonda Robles Donaldson, OTR

Figure 4. Handwriting suggestions for EMR and LD students

The OT provides training that is continuous.

Guidelines can be quite specific as to types of activities for direct OT versus those assigned to others (indirect). The OT does specialized techniques that the consultee is not qualified or authorized to do. Such OT-only interventions may include passive range of motion, stretching, and specific facilitation techniques. The rule of thumb is to choose activities that any student could do.

Observation of direct occupational therapy sessions is an important part of training the indirect OT staff person. The training is on-going. At times the consultation is more formal between the OT and the resource room teacher. Two to six times a year a substitute is hired to cover the traditional resource room activities, allowing the resource room teacher's time to be spent with the OT.

The OT adjusts the treatment activities based on feedback from the staff and student records. Figures 5 and 6 are examples of an activity sheet used to assign and monitor motor reinforcement activities.

RESOURCE ROOM

+ Success
> Approximation
0 Attempted

Date:

Objective:

Figure 5. Motor reinforcement program activity sheets

ALTA SCHOOL

RESOURCE ROOM

+ Success
> Approximation
0 Attempted

prone = on stomach

Monday

[redacted] Occupational Therapy

Plan I Date:

Objective:	2/9	2/16	2/22	2/29	3/7	3/7	3/21			
Warm Up: (Choose 2 or 3)										
Brisk rubbing/polishing extremities, spine/thorax	+	+	>	>	+	+	+			
log rolls, chin to chest, arms overhead	>	+	>	>	+	+	+			
somersaults 3-5x's (lands in sit, arms forward)	+		>	>	>		+			
joint compression - head, shoulder, arms, hips (vertical position)	+	+		+	+	+	+			
rocker - 5x's then stand	+		+		+	+	+			
- trunk curl				>			>			
wall push-ups										
Jumping Jacks	>			0			>			
Net Hammock or Scooterboard:										
spins self L & R 10x's	SB +	H +	SB +	SB +	Ham pidal rec	SB +	slow >			
walks hands back, holds against resistance, 10 sec		+			+	resist +	+			
cross river - pulls forward hand over hand	+	+	+	+	+	-	+			
holds for 10 sec. SB hands/scoot										
push - pull or pushes hands off of cageball 10x's		+			+	+	+			
boat ride - sitting, prone, kneel-stand	+					+				
pick up, transfer, drop various objects 5x's L & R		+			+		>			
crab walk					>					
cageball kick										
Sits on T-stool, no loss of balance										
uses scoops & bean bags 10x's	+	>	+*	+	+	+	+			
plays concentration		>		>	>					
practices sight words, spelling, etc.	+				+		+			
thumb glance 3-5x's	+	>	>	>	>		>			

Figure 6. Motor reinforcement program activity sheets

This sheet is also used to communicate specific questions for clarification. The job responsibility of the designated staff person is to use these sheets, talk about them, suggest practical changes or variations to the OT, and ask questions.

Such sheets are the treatment record for activities outlined by the OT. They are designed to be more of a worksheet/lesson plan than a formal data sheet. Yet, the end result is that it is a data collecting system to provide daily accountability. The scoring system is optional and subject to personally preferred modifications. Some students' assigned activities may be merely checked (✓) when carried out.

A scoring system of success, approximation, and attempt allows the OT a way to see change in the data of student performance. Some activities call for specific data, percent correct, number in a row, etc. This provides information for data-based decisions made by the OT.

Practical Considerations on Occupational Therapy and Resource Room Collaboration

The occupational therapist's education, training, and knowledge of human development compliments that of the resource room teacher. Our educational and experiential backgrounds differ and, although there may be a slight overlap, the philosophical orientation is clearly different.

Many educators tend to be more product-oriented, focusing on test scores, number of pages completed, reading level, and so forth. Occupational therapists tend to be more process-oriented they look at skills such as handwriting or reading as a complex developmental process which can be broken down into many sub-skills and components. Each view is equally valuable and can be combined or shared to provide a broader perspective which allows increased understanding of the relationship between motor deficits and academic deficits. This facilitates the development of more appropriate school programs. In our experience we have seen an increase in the teachers' understanding of OT and their students with

special needs, particularly in the classroom setting.

This approach requires personal commitment and some extra time initially on the part of all who are involved. One must be open-minded, willing to learn new ideas, and able to become a resource for another discipline. It is most important to recognize that not everyone can carry out indirect service/motor reinforcement programs. Just because staff persons have the time or the right job description, this does not automatically make them suitable.

On the other hand, the OT may not find the person who is perfect. We must also appreciate individual differences and styles. One must focus on the positive, balance out strengths and weaknesses, and attempt to make small steady changes in each person's performance. Positive feedback can be combined with constructive criticism. Don't expect too much too soon. Acknowledge that there is a difference between direct service and indirect service. Each option has advantages and disadvantages. It is important to

concentrate on what you can realistically accomplish, given the complexities of public education.

One of the great advantages of a collaborative approach is that there is shared responsibility and problem solving. Reinforcement comes from a job well done by facilitating solutions, seeing programs developed, and seeing a broader effect from our expertise. We can help each other to be better at what we do.

Many occupational therapists in school settings work in isolation, traveling between schools, and having little time for peer contact. This can be a source of frustration, leading to job dissatisfaction and premature burn-out. Being part of a school system can lead to friendships, personal as well as professional. This can make one's job more meaningful and satisfying. It is important to actively build rapport with administrators as well as educators. Occupational therapy is not always fully understood, and many school staff need to know what our profession has to offer them.

Success in this approach may require some

philosphical shifts on the part of the OT's. We must come to terms as an individual with the differences between the medical model and the educational model, constantly asking whether the child's goals will enhance their ability to benefit from educational programs. We must also change our focus of gratification. Sometimes it is the person working with the child directly who develops that special relationship and experiences the immediate rewards. Sharing our knowledge and skills with others does not diminish our professional integrity. A spirit of cooperation is necessary for the development of mutual trust and respect.

The resource room teacher can learn a great deal as the consultee. Analyzing a child's strengths, weaknesses, and learning styles can be like solving a mystery. The input of the OT adds clues to understanding a particular student. Much of the motor and perceptual testing used in special education is on a more superficial screening level. Yet some of our testing does overlap.

The OT utilizes a developmental approach. Such an approach is different because of its medically oriented background. It is different from the 3 R's, yet reading and writing have a developmental perspective that starts even earlier than kindergarten. For example, there are many steps in learning to hold a pencil correctly. This involves a complicated, sequential development of hand and finger musculature enabling one to hold the pencil and write legibly. If a child doesn't have a mature grasp, he or she won't be able to hold a pencil in the way the teacher demonstrates. This child could begin the at-risk-for-failure pattern, if his experience with writing is frustrated, negative, and unsuccessful. The more teachers understand about motor behaviors and developmental skills, the better for kids who have difficulty mastering these skills.

At the beginning of OT and resource room collaboration, the goals seem very technical and medically oriented. It becomes easier as one

becomes more familiar with the terminology of another discipline. The relationship can grow to the point of writing goals and objectives together. This begins as an on-going conversation when you work to coordinate and understand the goals and activities of common students.

Figure 7 is one example of writing a goal together. It was in response to the EMR 3rd Grader's difficulty with handwriting and in group art and craft projects. His handwriting was unacceptably erratic and he was a slow and careless cutter with scissors. Figure 1 previously discussed is a copy of his OT evaluation. Of the three objectives, one was strictly an OT-type activity and the others were more oriented to classroom skills. Both the OT and resource room teacher worked on and monitored these activities.

Another example of collaborating to write goals together was for a learning disabled 3rd grader. This child had not met minimum skill standards for handwriting in the classroom, and he was unable to accurately copy sentences from the blackboard.

SPECIAL EDUCATION DEPARTMENT

Goal and Objectives

Student C.A. 9.6

Goal initiated on (date): 12-3-87 Reviewed on (date): _____

LEVEL OF PERFORMANCE

PRE	POST
B.O.T.M.P. Fine Motor Subtests: Response Speed: 8.11 yrs. Visual-Motor Control: 9.2 yrs. Speed Dexterity: 6.11 (timed) VMI: Age Equivalent: 5.3 yrs. P.T. Tracing: 50% accurate, messy. P.T. Cutting: 70% accurate, too slow, doesn't use both hands.	

Goal # 2 : _____ will demonstrate improved speed and dexterity for fine motor movements.

Objective: 1 _____ will complete 10 Precision Teaching "Eye-Hand Coordination" worksheets tracing lines, 1 minute timings per page, mastery level, 100% accuracy.

Objective: 2 _____ will complete 3 Precision Teaching "Cutting" worksheets, 1 minute timings per page, mastery level, 100% accuracy.

Objective: 3. _____ will sort 20 ½ inch pellets into 4 piles picking each one up individually with a fine pincer grasp and releasing (not dropping) into a designated area with an initial model as needed, 100% accuracy.

Objective: _____

Objective: _____

Objective: _____

Figure 7. OT/resource room collaborative goal

SPECIAL EDUCATION DEPARTMENT

Goal and Objectives

Student _____ - 2nd Grade

Goal initiated on (date): 4-27-87 Reviewed on (date): _____

LEVEL OF PERFORMANCE

PRE	POST
Test of Visual/Perceptual Skills(non-motor) Visual Discrim. 11.8 Percpt.Age 84%ile Visual Memory 5.11 " 9 %ile Vis./Spatial Rel.5.6 " 5 %ile Vis.Form Constancy 12.11 " 99.9%ile Vis.Sequencial Mem.10.0 " 75%ile Vis.Figure Ground 4.5 " 1 %ile Vis. Closure 6.10 " 25 %ile Dev. Test of Visual Motor Integration: 6.10 Classroom Report Card Handwriting Grade: U Copied 7 sentences from blackboard 66% accuracy. Dictated letters accurate for size, slant, alignment, and spacing-manuscript: Uppercase: 38% Lowercase: 77% Wrote 3 sentence story,no capitals,unclear.	

Goal # 3 : _____ will demonstrate improved visual-perceptual-motor skills as measured by satisfactory handwriting skill performance in the regular classroom monitored by the Resource Room Teacher.

Objective:*1 _____ will legibly copy 5 sentences off the blackboard on to lined primary paper with 90% accuracy for spelling, capitalization, and punctuation.

Objective:*2 _____ will legibly print on lined primary paper all of the upper and lower case letters when dictated in separate groups, with 90% accuracy for letter size, formation, and alignment.

Objective:*3 _____ will legibly write 25 or more words or 3 sentences of creative writing that is understandable.

Objective:*4 _____ will accurately identify 2 and 3 step patterns in the computer program "The Pond" within the allowed number of moves for Levels 2,3, and 4 (Pre-Level 1 achieved).

Objective:*5 _____ will accurately match sizes and reproduce patterns by completing the Level 3 computer games of Early Discovery "Size and Logic" and "Pattern and Sequence" with 100% accuracy within 10 seconds, first attempt,

Objective:* with and without color. (Pre-80%).

Figure 8. OT/resource room collaborative goal

Figure 8 is an example of his combination goal. Standardized testing was completed by the OT. The classroom data was obtained by the resource room teacher. The objectives combine the practical classroom and perceptual skills.

Summary:

In this paper we have described a collaborative style of consulting between an occupational therapist and a resource room teacher in a small rural school. This is a practical approach which has worked well with these individuals in their particular circumstances.

Included are also a review of the history of occupational therapy, various models of service provision in schools, four consultation styles, and the implications of Public Law 94-142 for providing occupational therapy as a related service. Examples of collaborative programming are provided.

The information provided here is based on our practical experiences. The success of this style is based on several factors, but there is one that we consider paramount. It includes communication between

individuals; a sharing of ideas, resources, joint problem-solving, and at times compromise.

Learning to communicate effectively is a process. Flexibility on the part of all concerned can go a long way. Such cooperative planning serves to limit duplication; to efficiently assist more students, and it begins to address some of the financial dilemmas facing special education today.

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